STATE OF MICHIGAN
IN THE SUPREME COURT

Appeal from the Court of Appeals
(Kelly, M.J., and Murray, P.J., and Shapiro, JJ.)

Covenant Medical Center Inc.

Plaintiff-Appellant,

v

State Farm Mutual Automobile Insurance Company

Defendant-Appellee

Supreme Court No. 152758

Court of Appeals No. 322108

Saginaw Circuit No. 2013-020416-NF
Honorable Robert L. Kaczmarek

AMICUS CURIAE BRIEF OF THE COALITION PROTECTING AUTO NO-FAULT

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STATEMENT OF QUESTIONS PRESENTED

I. Does a healthcare provider have a legal right to assert a claim against a no-fault insurer that is both an independent and a derivative claim?

Amicus Curiae CPAN answers: YES

II. Does a healthcare provider constitute *"some other person"* within the meaning of the second sentence of MCL 500.3112?

Amicus Curiae CPAN answers: YES

III. Is a hearing always required under MCL 500.3112?

Amicus Curiae CPAN answers: NO

STATEMENT OF INTEREST OF AMICUS CURIAE

CPAN is a broad-based group consisting of 18 major medical groups and 7 consumer organizations. It was formed to preserve the integrity of Michigan's model no-fault automobile insurance system. CPAN's central mission is to protect and preserve the vitality of the Michigan auto no-fault insurance system so that it continues to provide comprehensive coverage and meaningful protections for Michigan citizens injured in motor vehicle collisions.

The resolution of the issues presented in this case could materially affect the right of all people injured in motor vehicle accidents covered by the Act to recover their personal injury protection (PIP) benefits. Thus, CPAN has an interest in this Court's resolution of the issues.

STATEMENT OF FACTS

A. Background information.

The relevant facts and background information regarding the initial dispute giving rise to this action are set forth in the Court of Appeals Opinion issued on October 22, 2015. In lieu of restating those facts, they are hereby adopted and incorporated as follows:

> *In 2011, State Farm's insured, Jack Stockford, was injured in a motor vehicle accident. In 2012, Covenant Medical provided medical services to Stockford for the injuries he sustained. Covenant Medical billed State Farm $43,484.80 for those services, sending bills in July, August, and October 2012. In November 2012, State Farm responded to the bills in writing. Subsequently, on April 2, 2013, in exchange for payment of $59,000, Stockford entered into a written agreement with State Farm that purported to release State Farm from liability "regarding all past and present claims incurred through January 10, 2013," as a result of the 2011 accident.*
>
> *Thereafter, Covenant Medical filed the instant action, alleging that State Farm had unreasonably refused to pay $43,484.80 for the medical services rendered to Stockford. State Farm moved for summary disposition, arguing that Covenant Medical's claims were barred by the settlement payments from State Farm to Stockford and the release signed by him as part of that settlement.*
>
> See JA, p 80a for a copy of the Court of Appeals Opinion.

B. Proceedings below.

The trial court granted summary disposition to Defendant-Appellee State Farm in an Opinion and Order dated May 15, 2014, on the basis that "*[n]o insurance benefits remain payable to or for the benefit of an insured under § 3112 when the claims have been settled by the insured and a valid release executed. That release ends the insurer's obligation to pay benefits to or on behalf of its insured under its contract of insurance.*" (See JA, p 76a, for a copy of the trial court's opinion).

Following the grant of summary disposition, Plaintiff Covenant filed a Claim of Appeal in the Court of Appeals on June 5, 2014. In a published Opinion dated October 22, 2015, a unanimous panel of the Court of Appeals REVERSED the trial court's grant of summary disposition and remanded this case for further proceedings on the basis that *"while a provider's right to payment from the insurer is created by the right of the insured to benefits, an insured's agreement to release the insurer in exchange for a settlement does not release the insurer with respect to the provider's noticed claims unless the insurer complies with MCL 500.3112."* JA, p 82a.

In an Order dated May 27, 2016, this Court granted leave to appeal the decision issued by the Court of Appeals and instructed the parties to address the following three issues:

> *"(1) whether a healthcare provider has an independent or derivative claim against a no-fault insurer for no-fault benefits; (2) whether a healthcare provider constitutes "some other person" within the meaning of the second sentence of MCL 500.3112; and (3) the extent to which a hearing is required by MCL 500.3112."*

After leave was granted, the Coalition Protecting Auto No-Fault (CPAN) moved for permission to file a brief amicus curiae. This Court granted CPAN's motion in an Order issued on June 22, 2016, which provided:

> *"On further order of the Chief Justice, the motion of the Coalition Protecting Auto No-Fault to participate as amicus curiae and file an amicus brief is GRANTED. The amicus brief shall be filed within the time provided by MCR 7.312(H)(3)."*

This brief is being submitted to the Court for consideration in these proceedings in accordance with this Court's June 22, 2016 Order.

STANDARD OF REVIEW

The issues involved in this appeal require interpreting the language of MCL 500.3112 of Michigan Auto No-Fault Act and therefore give rise to questions of statutory interpretation. Questions of statutory interpretation are reviewed by this Court *de novo*. *Madugula v Taub,* 496 Mich 685; 853 NW2d 75 (2014).

When interpreting a statute, this Court's goal is "*to give effect to the Legislature's intent, focusing first on the statute's plain language.*" *Id.* at 696. To do so, the Court will "*examine the statute as a whole, reading individual words and phrases in the context of the entire legislative scheme. When a statute's language is unambiguous, the Legislature must have intended the meaning clearly expressed, and the statute must be enforced as written. No further judicial construction is required or permitted.*" *Id.*

LAW AND ARGUMENT

I. Medical providers have enforceable claims for payment of services rendered because § 3112 of the Michigan Auto No-Fault Act specifically states that persons other than the injured person have claims, and the right to pursue such claims has long been consistently recognized in Michigan law.

As will be discussed below in detail, a medical provider's right to bring a direct action against a no-fault insurer for payment is clearly and unambiguously set forth in the language of MCL 500.3112 of the Auto No-Fault Act with such clarity that it has been consistently recognized and enforced by Michigan appellate courts for decades. Moreover, appellate courts further recognize that under the administrative rules promulgated by the Commissioner of Insurance, disputes between medical providers and insurers should be resolved without the involvement of the insured.

Thus, upon further review by this Court, it must be held that under § 3112 of the No-Fault Act, medical providers have legally enforceable claims for payment of no-fault benefits for medical services rendered to the injured victims of automobile accidents. To hold otherwise would fail to observe the rule of law intended by the Legislature, and it would improperly depart from longstanding Michigan appellate precedent contrary to the rules of *stare decises*.

A. The statutory text of the No-Fault Act confirms that providers have enforceable claims for payment.

As stated above, the relevant portion of the No-Fault Act that gives medical providers enforceable claims for payment is MCL 500.3112. This section provides:

"*Personal protection insurance benefits are* ***payable to or for the benefit of*** *an*

> *injured person or, in case of his death, to or for the benefit of his dependents. Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of* ***the claim of some other person.*** *If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or* ***any other interested person*** *may apply to the circuit court for an appropriate order. The court may designate* ***the payees*** *and make an equitable apportionment,* ***taking into account the relationship of the payees to the injured person*** *and other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:*
>
> > *(a) To the dependents of the injured person, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor.*
> >
> > *(b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse."*

When the language of this statue is properly analyzed, the phrase in the second sentence, "*claim of some other person,*" is of particular legal significance and must be construed as an express recognition that a third party has a legally-enforceable claim that can be asserted directly against a no-fault insurer.

In reaching this conclusion, it is first important to observe that the word "*claim*" is not defined in the No-Fault Act. It must therefore be interpreted according to its plain and ordinary meaning. See *Anzaldua v Neogen Corp*, 292 Mich App 626, 632; 808 NW2d 804 (2011)("*Terms that are not defined in a statute must be given their plain and ordinary meanings, and it is appropriate to consult a dictionary for definitions.*"). A review of various authorities confirms that the word "*claim*" is ordinarily understood to mean the assertion of a legally enforceable right.

Specifically, BLACK'S LAW DICTIONARY defines a claim as "*[a] legal assertion; a legal*

demand; Taken by a person wanting compensation, payment, or reimbursement for a loss under a contract, or an injury due to negligence." See BLACK'S LAW DICTIONARY, Free Online Legal Dictionary (2nd Ed. 2016).[1] Similarly, Michigan Courts have observed that "*the relevant dictionary definitions of the word 'claim' include a demand for something as due; an assertion of a right or an alleged right, and a request or demand for payment in accordance with an insurance policy. . . .*" See *Lakeland Neurocare Ctrs v State Farm Mut Ins Co*, 250 Mich App 35, 41; 645 NW2d 59 (2002)(internal quotations omitted). Thus, given its plain and ordinary meaning, the word "*claim*" must be construed to identify a legally enforceable obligation.

The phrase, "*of some other person*" is an adjectival phrase that modifies the type of "*claim*" being described. Thus, by using the word "*claim*" together with the phrase "*of some other person,*" the language of § 3112 must be interpreted as giving persons other than the injured person the right to make a legally enforceable demand for payment of PIP benefits directly against the no-fault insurer.

Furthermore, when properly read in context with the first sentence in § 3112 (which states that benefits are also payable "*for the benefit of*" the injured claimant), the phrase "*some other person*" must include a medical provider who has rendered services to an injured person that are covered under the No-Fault Act. Thus, the phrase "*claim of some other person*" must be construed as an express recognition that in addition to the injured person, third parties (i.e., such as medical providers) also have the right to assert claims for no-fault benefits directly against a no-fault insurer.

[1] Available at *http://thelawdictionary.org/claim/*.

Further examination of the statute bolsters this conclusion. The phrase "*to or for the benefit of*" contained in first sentence clearly identifies two types of payment obligations that a no-fault insurer has under the No-Fault Act—an obligation to pay benefits directly "*to*" the injured person (or a surviving dependent), and as well as an obligation to make payments "*for the benefit of*" the injured person (or a surviving dependent). The latter obligation to pay benefits "*for the benefit of*" the injured person unavoidably creates an obligation on the part of the no-fault insurer to pay benefits to some other third-party payee.

When these two types of payment obligations are properly recognized, the first sentence of § 3112 must be construed as identifying two separate classes of payees to whom an insurer is obligated to pay no-fault benefits: (1) an injured person (or a surviving dependent); and (2) a third party payee who has incurred allowable expenses "*for the benefit of*" the injured person (or a surviving dependent).

Finally, it is further significant that the third sentence of § 3112 contains a reference to ***"any other interested person,"*** and that the fourth sentence states that a court may designate ***"the payees"*** and make an apportionment, ***"taking into account the relationship of the payees to the injured person."*** These phrases obviously contemplate that beneficiaries or payees of no-fault PIP benefits can be persons other than the injured claimant.

B. Appellate case law has consistently enforced the right of providers to assert claims against insurers who do not pay benefits.

The clarity with which the Legislature has created a medical provider's right to make a claim in the language of § 3112 has resulted in a unique consistency in appellate case law confirming a provider's right of direct action. In the case of *LaMothe v ACIA*, 214 Mich App 577; 543 NW2d 42 (1995), the Court of Appeals observed:

> *" . . . we can anticipate that health care services providers, as practical litigants, would bypass the insured and directly sue, pursuant to third party beneficiary theories, the entity with prospects identical to their own for engendering jury sympathy-the insurer." Id.* at 585-586.

The following year, the Court of Appeals expressly recognized in *Munson Med Ctr v Auto Club Ins Ass'n*, 218 Mich App 375; 554 NW2d 49 (1996), that the plaintiff medical provider had a "*right to be paid for the injureds' no-fault medical expenses*" that arises under the Auto No-Fault Act. *Id.* at 381.

Then, in the case of *Lakeland Neurocare Ctrs v State Farm Mut Auto Ins Co*, 250 Mich App 35, 39; 645 NW2d 59 (2002), the Court of Appeals expanded on these principles, clarifying that:

> *"MCL 500.3112 specifically contemplates the payment of benefits to someone other than the injured person as reflected by its inclusion of the phrase "benefits are payable to or for the benefit of an injured person" and by its discharge of an insurer's liability upon payment made in good faith to a payee "who it believes is entitled to the benefits . . . ." As a result, it is common practice for insurers to directly reimburse health care providers for services rendered to their insureds."*[2]

[2] Citing as examples, the cases of *Mercy Mt Clemens Corp v Auto Club Ins Ass'n*, 219 Mich App 46, 48; 555 NW2d 871 (1996); *McGill v Auto Ass'n of Mich*, 207 Mich App 402; 526 NW2d 12 (1994); and *Hicks v Citizens Ins Co of America*, 204 Mich App 142; 514 NW2d 511 (1994).

The Court of Appeals further recognized in *Lakeland* that a medical service provider is considered to be a "*claimant*" under the Auto No-Fault law. In doing so, the Court explained:

> "*In this case, as discussed above, because plaintiff properly submitted a claim for personal protection insurance benefits for the benefit of defendant's insured, plaintiff was entitled to such payment within the time limits imposed by the no fault act. Consequently, plaintiff was a claimant within the plain meaning of the statute and, thus, had the right to attempt recovery of its attorney fees expended in pursuit of recovering overdue benefits.*" *Id.* at 41.

Shortly after the *Lakeland Neurocare* case was decided, the Court of Appeals issued another published decision in the case of *Regents of the Univ of Mich v State Farm Mut Ins Co*, 250 Mich App 719; 650 NW2d 129 (2002), wherein the Court recognized that the claims of the medical provider plaintiffs in that case were "*derivative claims, they also have direct claims for personal protection insurance benefits.*" *Id.* at 733.

Then, in the case of *Mich Head and Spine Inst, PC v State Farm Mut Auto Ins Co,* 299 Mich App 442; 830 NW2d 781 (2013), the Court of Appeals reiterated that under the language of § 3112 of the No-Fault Act, a healthcare provider has a legally enforceable right to assert a direct cause of action against a no-fault insurer for payment of benefits. In this regard, the Court stated in the context of interpreting a release agreement:

> "*We note that the language 'or on behalf of' in the release is similar to the phrase 'or for the benefit of' in MCL 500.3112, which this Court has recognized creates an independent cause of action for healthcare providers.*" *Id.* at 447 (citing *Lakeland Neurocare, supra* at 39).

This proposition was further recognized in the case of *Moody, et al v Home Owners*,

304 Mich App 415; 849 NW2d 31 (2014), lv granted 497 Mich 866; 853 NW2d 331 (2014)[3] where the Court of Appeals observed that a medical provider's right to claim no-fault benefits arises out of the insureds right to receive benefits, and a medical provider therefore has an independent right to bring a claim against an insurer for the payment of no-fault benefits. See *id.* at 442.

The development of this line of cases was discussed at length and reaffirmed in the more recent case of *Wyoming Chiropractic Health Clinic, PC v Auto-Owners Ins Co*, 308 Mich App 389, 396; 864 NW2d 598 (2014), lv den, 497 Mich 1029; 863 NW2d 54 (2015), where the Court of Appeals again held that the medical provider plaintiff in that case *"had standing to bring a cause of action against Auto-Owners for PIP benefits under the no-fault act."* In so holding, the Court of appeals made it clear that its conclusion in this regard was required by the language of §3112 as interpreted by the many decisions discussed above. In this regard, the court observed:

> *[A]s discussed. . ., this Court interpreted the plain language of MCL 500.3112 as allowing healthcare providers to maintain direct causes of action against insurers to recover PIP benefits under the no-fault act.67 Therefore, the Michigan Legislature addressed the public policy issues related to healthcare provider standing when it drafted MCL 500.3112. Id.* at 401.

The court then went on to further emphasize the importance of this provider right of direct action, and in that regard stated:

> *". . . the public policy goals of the no-fault act support allowing a healthcare provider to have standing to sue an insurer for PIP benefits. Auto-Owners argues that this rule will force insurers to defend multiple lawsuits at different times and in different courts. Auto-Owners also points out that insurers face an increased*

[3]This appeal was later dismissed by Order of this Court dated February 4, 2015 (Docket No. 149046)

> *risk of having to pay penalty interest if healthcare providers have standing to sue because insurers will not be able to concentrate their efforts on paying insured individuals on time and at "fair and equitable rates." However, as discussed earlier in this opinion, this Court interpreted the plain language of MCL 500.3112 as allowing healthcare providers to maintain direct causes of action against insurers to recover PIP benefits under the no-fault act. Therefore, the Michigan Legislature addressed the public policy issues related to healthcare provider standing when it drafted MCL 500.3112.*
>
> *Furthermore, public policy favors provider suits. The goal of the no-fault act is "'to provide victims of motor vehicle accidents with assured, adequate, and prompt reparation for certain economic losses.'" The no-fault act was designed to remedy "'long delays, inequitable payment structure, and high legal costs'" in the tort system. Allowing a healthcare provider to bring a cause of action expedites the payment process to the healthcare provider when payment is in dispute. Thus, provider standing meets the goal of prompt reparation for economic losses. Healthcare provider standing also offers a healthcare provider a remedy when an injured individual does not sue an insurer for unpaid PIP benefits, thus preventing inequitable payment structures and promoting prompt reparation. Therefore, public policy supports this Court's prior opinions. For the reasons stated in this opinion, the trial court properly denied Auto-Owners's motion for summary disposition. Wyoming Chiropractic had standing to sue Auto-Owners for PIP benefits under the no-fault act." Wyoming Chiropractic, supra* at 401.

This decision in *Wyoming Chiropractic* hits upon a fundamental basis for the right of direct action. Beyond the clear text of § 3112, this right is rooted in the fundamental nature of the relationships between and among injured persons. These relationships are discussed in the next section.

Following the *Wyoming Chiropractic* decision, the Court of Appeals again recognized a provider's direct right of action in the recent case of *Chiropractors Rehabilitation Group, PC et al v State Farm Mut Auto Ins Co*, 313 Mich App 113; 881 NW2d 120 (2015). In doing so, the Court of Appeals again emphasized that this right is a statutory right that arises out of the text of the no-fault act. In this regard, the court observed:

> *" . . . a healthcare provider's right to reimbursement for medical expenses in a first-party no-fault action is evident in the statutory language of MCL 500.3112, especially when the language is considered in context with MCL 500.3105, 500.3107, and 500.3157. MCL 500.3112 states, in pertinent part, that "[p]ersonal protection insurance benefits are payable to or for the benefit of an injured person or, in the case of his death, to or for the benefit of his dependents." MCL 500.3112 (emphasis added). "The word 'or' is a disjunctive term indicating a choice between alternatives." Jesperson v Auto Club Ins Ass'n, 306 Mich App 632, 643; 858 NW2d 105 (2014). Accordingly, the plain language of the statute reveals a Legislative intent to allow either the injured person or a party that provided benefits to an injured person to recover the payment of benefits from an insurer; the injured person is not the only party who has this right."Id. at 123-24*

To this end, the foregoing body of case law not only confirms that the medical provider's direct right of action is set forth in the clear and unambiguous language of § 3112 of the No-Fault Act, but also that this right of action is well engrained in Michigan auto no-fault jurisprudence. Failing to uphold this right now would needlessly disrupt the fabric of the law in violation of the principles of *stare decisis*.

C. The Michigan Insurance Commissioner and the Court of Appeals have recognized that disputes over payment amounts should only be between insurers and providers, and patients should not be involved in these disputes.

The critical importance of resolving disputes between medical providers and insurers without the involvement of the insured has been expressly recognized by the Michigan Commissioner of Insurance. Notably, the Commissioner recognized that disputes between insurers and medical providers should not involve the patients and should be handled in such a way that any litigation resulting from such a dispute should be between the insurer and the provider only, and consistent with this, insurers have a duty to protect their insureds. This duty requires that insurers take all appropriate steps to shelter the insured from legal proceedings regarding the dispute. In this regard, Bulletin 92-03 states:

> *"The Insurance Bureau has received reports that no-fault insurers have questioned the reasonableness of some of the charges billed by health care providers for services rendered to their insureds and claimants following a motor vehicle accident. In some instances where the insurer and the provider have been engaged in such a dispute, the health care provider has billed the patient for the disputed amount and has vigorously pursued collection from the insureds or claimant directly.*
>
> *The purpose of this bulletin is to remind no-fault insurers that they are required to provide insureds and claimants with complete protection from economic loss for benefits provided under personal protection insurance. Auto insurers must act at all times to assure that the insured or claimant is not exposed to harassment, dunning, disparagement of credit, or lawsuit as a result of a dispute between the health care provider and the insurer.*
>
> *When such a dispute arises, an insurer will meet its statutory obligations by adhering to the following procedures. First, the insurance company must assume its statutory responsibility for complete protection of the insured. To do so, the insurer should notify the provider that the insurer is responsible for paying any reasonable charges, not the insured or claimant. Second, the insurer must also assure the policyholder or claimant of its responsibility. Insureds and claimants*

> *should be given directions on how to handle any bills or collection notices they receive. Third, the insurer should notify collection agencies and credit reporting agencies to disregard medical providers' claims against the insured for services covered under personal injury protection benefits. And finally, health care providers should be warned that the insurer will defend the insured or claimant against any attempt to collect, and may also consider any other appropriate action to prevent its policyholder from being pursued for collection.*
>
> *A dispute between a medical provider and the insurer as to the reasonableness of the charge for services does not void the insurer's obligation to its insureds and claimants to pay the amount ultimately determined to be reasonable. The insurer also has an obligation to protect its insureds and claimants from any consequences of such a dispute.*
>
> *A dispute between a medical provider and the insurer as to the reasonableness of the charge for services does not void the insurer's obligation to its insureds and claimants to pay the amount ultimately determined to be reasonable. The insurer also has an obligation to protect its insureds and claimants from any consequences of such a dispute.*
>
> (For the Court's convenience, a copy of this bulletin is attached hereto).

While the context of this bulletin involves a duty of protection owed to an insured, it underscores the more important point—that when a dispute over medical expenses arises, resolution of the dispute should involve only the medical provider and the insurer. The correctness of the conceptual analysis of Bulletin 92-03 was recognized by the Court of Appeals in the case of *McGill v Auto Ass'n of Michigan,* 207 Mich App 402; 526 NW2d 12 (1994), where the court stated:

> *"While the Commissioner of Insurance's Interpretative Statement, Bulletin 92-03 does not have the full force or effect of law, [Michigan courts] generally give deference to administrative agency interpretations." Id.* at 407, note 1 (citing MCL 24.203(6); and *DAIIE v Commissioner of Insurance,* 119 Mich App 113 (1982).

Accordingly, Bulletin 92-03 should be viewed as persuasive authority for the proposition that legal disputes between medical providers and insurers will continue to

remain inevitable, and that resolution of these disputes should occur in a direct action between the provider and the insurer—without compelling the involvement of the insured.

This conclusion is further confirmed by Michigan appellate case law involving disputes between insurers and medical providers. In *McGill*, *supra*, plaintiffs incurred medical expenses. Defendants acknowledged their duty to pay but declined to pay the full billed amounts, asserting that the amounts billed were unreasonable. Defendants paid to plaintiffs' health care providers amounts that defendants deemed reasonable. Plaintiffs were concerned that the providers would sue plaintiffs for the outstanding balance, though the providers had not done so. Defendant promised that they would defend and indemnify plaintiffs if the providers ever did sue, and that it would attempt to protect plaintiffs from bad credit reporting in the event the health care providers pursued collection directly from plaintiffs.

The Court of Appeals in *McGill* dismissed the suit on the basis that plaintiffs suffered no damage in the case. The basis for the Court's opinion was that plaintiff had been held harmless from the service provider's claim. Although the insurer had promised to defend and indemnify the plaintiff, the Court held that the insurer was already required to do so by virtue of the Insurance Bulletin cited above:

> *"Furthermore, defendants have stated expressly that they will defend and indemnify plaintiffs in the event that plaintiffs are sued by their providers for the outstanding balance.* ***Indeed they are directed to do so by a recent Interpretive Statement issued by the Commissioner of Insurance...Accordingly, plaintiffs are protected, by both the defendants' promise and the directive of the Commissioner of Insurance****, from incurring damages as a result of defendants' payment of less than the full amount billed by plaintiffs' health care providers." Id* at 407.

Therefore, the Court in *McGill* clearly stated, that the insurers' obligation to defend and indemnify exists ***whether or not*** the insurer actually offers and agrees to defend and indemnify. As recognized by the Insurance Bulletin and adopted by *McGill*, the duty to defend and indemnify arises out of the nature of the relationship between the insured, his/her service providers, and the insurer. That relationship, one of vulnerability and exposure of the insured to claims of service providers, requires the insurer's protection.

After reading *McGill*, one might well ask what additional significance is gained by the insurer's promise to defend and indemnify. I.e., if the insurer *already* had such a duty as indicated by the Insurance Bulletin and *McGill*, does the additional promise to defend and indemnify have any significance? This question is answered in *LaMothe v ACIA*, 214 Mich App 577; 543 NW2d 42 (1995). The facts of *LaMothe* were very similar to those of *McGill* in. In *LaMothe*, defendant no-fault insurer again paid only the benefits they determined were reasonable. Defendant again agreed to defend and indemnify their insureds in the event that the medical providers filed suit against the insureds. The *LaMothe* dissent raised the concern that providers would be able to sue patients for 6 years, while the insured could only bring no-fault claims for 1 year:

> *"Plaintiff also argues that a rule requiring that the insured first to be sued by a medical provider for nonpayment before an injury is said to have occurred could expose an insured to an unprotected five years of liability. This argument has merit. An insured has only one year in which to file a claim for benefits while a medical provider has six years in which to file suit for nonpayment of a bill." Id at 589-590.*

However, the Court's majority made clear that the insurer's additional promise to defend and indemnify places an obligation on the insurer ***beyond*** that imposed by the

no-fault law alone. The additional promise is enforceable beyond the limitations period governing ordinary no-fault claims:

> *"This promise is enforceable regardless of the period of limitation in the policy that controls presentment of claims to the insurer. Thus, the fact that that period is shorter than the period the provider has to sue the insured is irrelevant to the enforcement of the insurer's promise,* ***supplemental to the policy****, to defend and indemnify whenever the provider might sue the insured." Id,* fn 5, p585, (emphasis supplied).

The additional promise to defend and indemnify ***beyond*** the already existing duty to defend and indemnify gives additional protection to the insured, protecting the insured from exposure to claims beyond the no-fault 1 year limitation on pursuing claims.

The Court in *LaMothe* understood that there would inevitably be disputes between provider and insurer. As mentioned above, the Court understood that the best way to manage such disputes was for the provider to sue the insurer directly:

> "***Thus, we can anticipate that health care services providers, as practical litigants, would bypass the insured and directly sue, pursuant to third party beneficiary theories, the entity with prospects identical to their own for engendering jury sympathy–the insurer.***" *Id.* at 585-586, emphasis supplied.

The third-party beneficiary status referenced in the above quote requires that the third party be an *intended beneficiary* of the contract between the primary parties. MCL 600.1405; *Koenig v City of South Haven*, 460 Mich 667; 597 NW2d 99 (1999). The above discussion makes clear that the insurer's duty to its insured confers that very intended beneficiary status on the provider.

The foregoing discussion makes clear that allowing service providers to directly sue no-fault insurers best promotes the fundamental purpose of the no-fault law ***to***

protect insureds by keeping insureds out of the middle of payment disputes between insurer and service provider. Appellant and its Amici simply ignore and dismiss this purpose. Their solution will ensure the exposure of their insureds to liability for claims from their service providers. The structured protection envisioned by the Insurance Bulletin and the *McGill* and *LaMothe* decisions will no longer exist.

II. The claim of a medical provider under the Michigan No-Fault Act is an independent claim that is derivative of the injured person's legal entitlement to recover no-fault benefits and, as such, is similar to independent and derivative claims for loss of consortium—the existence of which, this Court has recognized in the context of the Michigan Auto No-Fault Act.

As will be discussed in detail below, independent medical provider claims are derivative claims that are conceptually no different than traditional derivative claims for loss of consortium. It has long been held in Michigan that although a loss of consortium claim is derived from the injury that was suffered by the person's spouse, the uninjured spouse's claim for loss of consortium claim is nonetheless recognized as being a wholly separate and independent claim that cannot be resolved or settled by the injured spouse. In the case of *Rusinek v Schultz*, 411 Mich 502; 309 NW2d 163 (1981), this Court expressly recognized the continued validity of common law derivative claims for loss of consortium in an auto tort action brought under § 3135 of the No-Fault Act. Therefore, the same principles that apply to these derivative claims should also be recognized as applying to medical provider claim brought under § 3112 of the No-Fault Act.

As it relates to the derivative nature of a provider's claim, the service provider's

right of direct action, of course, must initially derive from the injured person's right to claim benefits. It is obvious that the injured person must have "*bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle*" before a service provider obtains any rights under the no-fault law. MCL 500.3105. And, of course, if the injured person is disqualified under §3113, the provider would also be disqualified. In a similar context, in *Belcher v Aetna Casualty and Surety Co*, 409 Mich 231; 293 NW2d 594 (1980), the Supreme Court held that the disqualification provisions of §3113(b), applicable to uninsured owners of motor vehicles involved in the accident, also apply to claims for survivor's loss benefits filed by the surviving dependents of the uninsured owner of a motor vehicle involved in the accident. The Court specifically held that the surviving dependents had the same right to recover no-fault benefits as the decedent:

> "*In this way, a survivor's entitlement to benefits may be said to be derivative of or dependent upon the deceased injured person's entitlement to benefits had he survived.*" *Id* at 255.

Finally, of course, the responsible insurance company is determined by a priority scheme derived from the injured person's insurance coverage. MCL 500.3114, 3115.

Therefore, the provider's right of direct action is initially derivative of the injured person's right to claim benefits. But that initially derivative right of action also becomes an independent and direct right of action. As observed in *Regents of the University of Michigan v State Farm*, 250 Mich App 719; 650 NW2d 129 (2002): "*Although plaintiffs may have derivative claims, they also have direct claims for personal protection insurance benefits.*" *Id.* at 733. This issue is quite analogous to the common law claim for loss of consortium. Loss of consortium claims also arise from an injury to a spouse. The injured spouse has a claim

for tort damages against the tortfeasor for loss of consortium. The uninjured spouse also has a claim for tort damages against the tortfeasor, for loss of consortium (i.e., loss of services of the injured spouse to the uninjured spouse). See e.g., *Montgomery v Stephan*, 359 Mich 33; 101 NW2d 227 (1960). Consortium claims continue to be viable under the no-fault law in spite of its conditional abolition of tort claims. This was recognized by this Court in *Rusinek v Schultz*, 411 Mich 502, 504; 309 NW2d 163 (1981), where this Court held *"that Michigan's no-fault act has not abolished the common-law action for loss of consortium."* This is an important pronouncement by the Court that the principles of consortium law continue to be relevant under the no-fault law. This includes the independent rights of consortium claimants to separately pursue loss of consortium claims.

Relevant to the provider's right of direct action under the no-fault law, our jurisprudence makes clear that a consortium claim is both derivative and independent. As with our no-fault PIP provider claims, the consortium claim derives from an injury to a spouse. As with no-fault PIP provider claims, there can be no consortium claim unless there is an injury to a person with a legally recognized relationship to the consortium claimant (e.g., spouse or minor child). However, that initially derivative consortium claim may be brought independently from the primary plaintiff's tort claim.

The critical distinction between the initial derivation of the claim and the independent right to pursue the claim was confirmed by this Court in *Eide v Kelsey-Hayes Company*, 431 Mich 26; 427 NW2d 488 (1988). At issue was whether consortium claims were permitted under the Michigan Civil Rights Act. This Court confirmed that consortium claims could indeed be brought. In so doing, the Court confirmed that

consortium claims were derivative only in that initial sense that an injury to a primary plaintiff is a condition precedent to an action for consortium. The Court made clear, however, that the resulting consortium claim is thereafter independent:

> "As Justice GRIFFIN explains, a claim for loss of consortium is usually considered to be derivative, ***but only in the sense that it does not arise at all unless the other, impaired spouse has sustained some legally cognizable harm or injury. Thus, courts have consistently treated loss of consortium not as an item of damages, but as a separate cause of action***. Montgomery, supra. See also Prosser Keeton, Torts (5th ed), § 125, pp 931-934. ***This fact is often obscured by the use of the term "derivative" and also by the common procedural requirement that the claim be joined with that of the impaired spouse***." *Id*. at 29, (emphasis supplied).

This Court in *Wesche v Mecosta County Road Commission*, 480 Mich 75; 746 NW2d 847 (2008) continued to make clear that consortium claims are independent of the injured person's claim:

> ***"Moreover, loss of consortium is not merely an item of damages. Rather, this Court has long recognized that a claim for loss of consortium is an independent cause of action.*** *Eide, 431 Mich at 29 (citing Montgomery, 359 Mich at 49, and* PROSSER & KEETON, TORTS *(5th ed), §135, pp 931-934).* ***Although a loss of consortium claim is derivative of the underlying bodily injury, it is nonetheless regarded as a separate cause of action and not merely an item of damages.*** *Wesche, supra,* at 85(quoting *Eide, supra at 37*).

Accentuating the independent nature of the consortium claim is the fact that a consortium claim cannot be settled or released without consent of the consortium claimant. This was made clear in *Oldani v Lieberman*, 144 Mich App 642; 375 NW2d 778 (1985), where Judith and Harry Oldani were husband and wife at the time Judith received medical care with defendants which caused her injury. Judith sued for medical malpractice. During the pendency of the medical malpractice case, Judith also filed for divorce. During the pendency of Judith's medical malpractice case, Harry filed a separate

complaint for consortium damages. Judith eventually settled her malpractice claim and released her claims against all defendants. Harry's separate claim was dismissed based on the release executed by Judith. The Court of Appeals reversed. The Court acknowledged that in Michigan a loss of consortium claim is derivative and contingent upon the injured spouse's right to recover damages. In what appears to be dicta, the Court was critical of the trial court's refusal to permit the husband to join or consolidate his consortium claim with his wife's principal claim.

However, the *Oldani* Court noted that even if joinder or consolidation had been permitted, *". . . the same issue would arise, namely, what effect should be given to Judith's settlement of the principal claim against defendants." Id*. at 647. The Court recognized that the husband's consortium claim is an independent claim that cannot be settled without the husband being a party and signatory to the settlement of the principal claim. In this regard the Court held:

> *"In the usual case, where a husband and wife bring a principal claim and an additional loss of consortium claim in the same suit, a settlement is only made with both parties. More specifically, a defendant settling with two such plaintiffs would be expected to make a payment to the two plaintiffs, to take releases from each, and to seek entry of an order dismissing the case as to each. However, the within case is not the usual case, for the reason that the two plaintiffs, Harry and Judith, were in the midst of a divorce case, and there does not appear to have been any joint settlement whereby Harry would receive any of the settlement money. In such a situation, we are reluctant to hold that Harry's loss of consortium claim has been released by the fact of an executed release by Judith and payment to her of substantial sums." Id. at 647.*

Therefore, the husband's consortium claim was not barred by the wife's settlement and release. In so concluding, the Court of Appeals relied on *Caroll J. Miller*, ANNOTATION,

INJURED PARTY'S RELEASE OF TORTFEASOR AS BARRING SPOUSE'S ACTION FOR LOSS OF CONSORTIUM, 29 ALR4th 1201 (1984):

> *"'Where a person who has been injured reaches a settlement agreement with the party who injured him, and in so doing executes a release by which he relieves the tortfeasor of all future liability for his injuries, the question has arisen as to whether the injured person's spouse may then bring an action for loss of consortium suffered as a result of the same injury. Where the action for loss of consortium is seen as purely derivative of the original cause of action for the injury, it has been held that once the original cause of action has been released, the action for loss of consortium is also barred.* ***However, the more prevalent view seems to be that the loss of consortium suit is not barred as it is a separate and independent cause of action which is the property of the spouse and cannot be controlled by the injured person.****'" Id at p648. (Emphasis supplied)*

The Court in *Oldani* concluded:

> *"Under these circumstances, where Harry was kept out of Judith's suit through no fault of his own, Judith's settlement with defendants did not operate to release Harry's claims against defendants. Judith did not have authority to settle and release Harry's claim. Therefore, the trial court erred in granting accelerated judgment in favor of defendants and against Harry's loss of consortium claim. Accordingly, we reverse and remand this case to the trial court for trial of Harry's loss of consortium claim." Id at 650.*

Therefore, Michigan has long and consistently recognized that consortium claims are initially derivative but otherwise independent of the injured person's claim. A consequence of this independence is that the injured person does not have the power to release the independent consortium claim. That power rests exclusively with the person who holds the independent consortium claim.

The consortium analogy is perfectly applicable to the relationship between injured person and service provider under the no-fault law. That is, the provider's claim, while initially derivative, is ultimately independent. As such, the injured person cannot release the provider's claim. If anything, this concept of independence is even stronger in no-fault PIP cases where the injured person incurs liability to the provider under

3107(1)(a) and by virtue of financial responsibility statements that are typically signed by the patient.

Finally, in further recognition of the fact that a derivative consortium claim is also fully independent, Michigan appellate law does not require their mandatory joinder. Although the court noted in *Eide, supra,* and suggested in dicta, that consortium claims should be joined with the principle claim, the earlier case of *Oliver v Department of State Police*, 160 Mich App 107; 408 NW2d 436 (1987), clearly held that joinder was not required, and that any previous pronouncements to the contrary, including the decision in *Oldani,* were dicta, and were not binding pronouncements of Michigan case law. In this regard, the Court of Appeals held:

> *["] Nowhere in any Michigan case is there a requirement that a claim such as this must be joined under the mandatory joinder rules of MCR 2.205 . . . . We believe the lower court was right in it[s] ruling that Michigan law does not require a consortium claim to be joined to the claims raised by the principal plaintiff [." Id] . [at 112] . . . .*

Nevertheless, procedural remedies such as joinder and consolidation can be used effectively to resolve any procedural inefficiencies such as those complained of by Appellant and its Amici. Those inefficiencies are better dealt with in this fashion, i.e., by procedural rules such as joinder, rather than by eliminating the providers' right of action.

III. Eliminating the right of medical providers to pursue independent claims for payment of services rendered would have ruinous consequences that would be completely inconsistent with the goals and objectives of the Michigan Auto No-Fault Act.

When the implications of eliminating the well-established right of a medical provider to bring a direct action against an insurer are properly examined, numerous deleterious consequences become manifestly clear. Examples of such consequences include the following.

A. Weakened Enforcement.

It is well understood that the principle goal of the Michigan Auto No-Fault Act is to provide prompt and adequate payment of benefits to the victims of auto accidents. That goal was succinctly described by this Court in the case of *Shavers v Attorney General*, 402 Mich 554, 578-79; 267 NW2d 72 (1978) as follows:

> *The Michigan No-Fault Insurance Act ... was offered as an innovative social and legal response to the long payment delays, inequitable payment structure, and high legal costs inherent in the tort (or "fault") liability system. The goal of the no-fault insurance system was to provide victims of motor vehicle accidents assured, adequate, and prompt reparation for certain economic losses . . . . Under this system, victims of motor vehicle accidents would receive insurance benefits for their injuries as a substitute for their common-law remedy in tort.*

If medical providers are denied the right to bring their own claims against no-fault insurance companies for payment of medical services they render to auto accident victims, the burden of enforcing payment will fall on the patients, many of whom will not have the ability to pursue such claims. This would allow insurers to deny payment of medical care expenses with virtual impunity—a situation that would totally frustrate the central purpose of the Michigan Auto No Fault Act.

In particular, patients are, all too often, ineffective at enforcing a no-fault insurer's obligation to pay benefits. They are often uncooperative and unresponsive to medical billing requests, they are unaware of critical statutory time periods that must be strictly adhered to in order to preserve a claim, such as the one-year-back rule, and they are reluctant or unable to retain an attorney to assist them with the enforcement of their no-fault claim. Urban hospital members of CPAN can readily attest that patients, once discharged, often disappear, and simply leave behind substantial unpaid bills.

In *Wyoming Chiropractic, supra,* the court recognized these harsh realities and therefore recognized that the right of a medical service provider to pursue a direct action against a no-fault insurer is central to accomplishing the no-fault act's goals. In this regard, the Court in *Wyoming Chiropractic* correctly observed that:

> *[P]ublic policy favors provider suits. . . . Allowing a healthcare provider to bring a cause of action expedites the payment process to the healthcare provider when payment is in dispute. Thus, provider standing meets the goal of prompt reparation for economic losses. Healthcare provider standing also offers a healthcare provider a remedy when an injured individual does not sue an insurer for unpaid PIP benefits, thus preventing inequitable payment structures and promoting prompt reparation. Wyoming Chiropractic, supra at 401.*

B. Reduced Access to Medical Care.

Medical providers who cannot pursue claims against insurers for unpaid services to auto accident patients may be reluctant to treat auto accident patients, thereby impairing access to medical care for auto accident related injuries. Specifically, eliminating the right of direct action will undoubtedly decrease revenue for service providers. That reimbursements will decline is a certainty. That is because

reimbursement will now depend upon the availability, the willingness to cooperate, and the collectability of the patient. Each of these is in significant question.

The consequences of decreased revenue include: reduced availability of medical care; decreased willingness to treat auto trauma patients due to uncertainty of payment; and lower profitability. Insurers already have a host of tools to contain service provider reimbursement, including the use of contracted reviewers. Insurers already use these tools in an extremely aggressive fashion. We have already experienced provider refusal to treat auto trauma patients because of the difficulty in meeting the various predicates for payment under the no-fault law, and the resulting uncertainty and delay in obtaining payment.

C. Patient Hardship

Without the ability to bring a direct action against an insurer, Medical providers who are not paid for services rendered to auto accident victims will often be forced to file legal action against their patients. This will add to the burdens and hardships suffered by auto accident victims and precipitate unnecessary litigation. In the *Miller v Citizens*, 490 Mich 904; 804 NW2d 740 (2011) this Court observed that the nature of the relationship between the patient and provider is one of debtor and creditor.

In *Miller*, the patient's attorney settled the claim for no-fault benefits as against the no-fault insurer. The Court confirmed that the patient's settlement extinguished the patient's claim *against the no-fault insurer* for no-fault benefits. However, this Court took care to point out that the patient's settlement did not release the provider's right to receive payment from the patient for the medical services rendered. The Court explained:

> *"Of concern to this Court is that the circuit court's order, and the Court of Appeals' affirmance, could be mistakenly interpreted as extinguishing the DMC's the DMC's contractual right to payment for its services. We wish to make clear that this is not the case. No-fault benefits are 'payable to or for the benefit of an injured person....' MCL 500.3112. In this case, through settlement, the benefits were paid to plaintiff, and her attorney asserted an attorney's charging lien over the settlement proceeds. Thus, the effect of this was only to settle claims as between the insurer, plaintiff, and her attorney. The circuit court's order of dismissal pursuant to the settlement agreement did not have the effect of extinguishing the DMC's right to collect the remainder of its bill from plaintiff. Such a result could not have been achieved without an explicit waiver, or at least unequivocal acquiescence, by the DMC, which was not obtained."*

As demonstrated by *Miller,* if the provider cannot bring an action against the no-fault insurer to recover benefit payments, the patient will most likely be sued. Direct collection actions against the *patient*, instead of the *insurer*, is problematic in a number of ways.

In particular, such actions will be disruptive to the doctor/patient relationship. It has been recognized that *"[t]he doctor-patient relationship has been and remains a keystone of care: the medium in which data are gathered, diagnoses and plans are made, compliance is accomplished, and healing, patient activation, and support are provided."* LIPKIN ET AL, THE MEDICAL INTERVIEW: CLINICAL CARE, EDUCATION, AND RESEARCH, NEW YORK, NY: SPRINGER-VERLAG; (1995).

Indeed, in Michigan, the physician/patient relationship is considered to be a *"special relationship"* for purposes of the duty owed by physician to patient. *Hill v Sears, Roebuck and Co*, 492 Mich 651; 822 NW2d 190 (2012). The special relationship is a recognition that the patient:

> *"...entrusts himself to the control and protection of [the physician], with a consequent loss of control to protect himself. The duty to protect is imposed upon*

> *the person in control because he is best able to provide a place of safety."Id.* at 666, citing *Williams v Cunningham Drug Stores,* 429 Mich 495, 499; 418 NW2d 381 (1988).

An obvious consequence of redirecting litigation against patients is that patients will be exposed to liability (and adverse credit reporting). Preventing this result is exactly why insurers have a duty to protect their insureds. Appellant and its Amici attempt to shed this responsibility without regard to the consequences to their insureds. It will not be lost on this Court that the physician, like the insurer, has a duty to protect the patient. Applicant and its Amici would compromise both duties, to the detriment of both patient and provider and to the benefit only of the insurer.

D. Cost Shifting

Medical providers who cannot legally compel an insurer to pay for services rendered to auto accident patients, and who realistically cannot expect to obtain reimbursement from their patients, ***will be forced to pass along the costs of these unreimbursed medical expenses to all patients, thereby increasing the cost of healthcare for all Michigan citizens.***

One obvious example of this can be observed in the context of Medicaid. Medicaid is deemed to be secondary to those that have no-fault available to pay their bills. *Workman v DAIIE,* 404 Mich 477; 274 NW2d 373 (1979). Where no-fault is no longer available, Medicaid would become primary. This would dramatically drive up Medicaid costs while at the same time reimbursements to the providers would be a fraction of what is paid under the no-fault system.

Similarly, service providers who cannot legally compel a no-fault insurer to pay

for services rendered to auto accident patients, and who realistically cannot expect to obtain reimbursement from their patients, will be forced to pass along the costs of these unreimbursed medical expenses to all patients and therefore their other payors, thereby increasing the cost of healthcare to all Michigan citizens. As noted in *McGill v AAA, supra* 207 Mich App at 407-408 (1994), "*[i]t is to be recalled that the public policy of this state is that the existence of no-fault insurance shall not increase the cost of health care.*" (citing *Dean v Auto Club Ins Ass'n*, 139 Mich App 266, 274; 362 NW2d 247 (1984)).

It should be plain by now that removing the service provider's independent right of direct action may benefit no-fault insurers at the expense of everyone else: patients; service providers; and taxpayers. The Court of Appeals in the *Wyoming Chiropractic* case discussed above concluded that the right of direct action was consistent with sound public policy. That wisdom is manifest.

IV. The third sentence of § 3112 of the Auto No-Fault Act evidences a clear intent that a hearing under that section is required only in situations where an insurer does not dispute its legal obligation to pay a claim for benefits and only seeks judicial involvement to determine the proper identification of the payee—not in situations where the insurer has contested its legal obligation to pay the claim and the matter has resulted in litigation against the insurer.

When the language of § 3112 is faithfully applied in the manner intended by the Legislature, it is clear that § 3112 was created as a procedural mechanism for insurers who do not dispute that they owe benefits, but who do not know who should receive the payment. In other words, it is a mechanism designed to avoid litigation, not designed to determine the outcome of litigation. In essence, it is analogous to something akin to "pre-suit impleader." The circumstances in which a person may seek an appropriate order from the circuit court are set forth in the third sentence of § 3112. This sentence provides:

> *"If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit court for an appropriate order."*

The language chosen by the Legislature in drafting this sentence clearly sets forth a condition precedent and only permits a person to seek an appropriate order from a circuit court *"if there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto . . . ."* Thus, the procedure in § 3112 only becomes applicable *"if"* doubt exists in either of these two situations.[4] Absent the

[4] Classic examples of § 3112 scenarios would include situations where a patient required 24/7 attendant care that was provided by multiple family members where there is no doubt as to the total amount owed by a no-fault insurer for the care, but there is a doubt about how much each family member is entitled receive out of that total amount. Similarly, a § 3112 hearing would be applicable in cases where a decedent left two minor

existence of such doubt, the procedure in § 3112 is inapplicable. There is nothing in the language of § 3112 that in any way suggests that the procedural mechanism identified therein can or should be used to litigate the gateway question of whether an obligation to pay benefits is owed in the first place. Thus, a holding to the contrary will impermissibly expand the scope of the procedure intended by the Legislature in drafting § 3112.

Moreover, a holding to the contrary will improperly allow insurers to exploit this procedure as a mechanism for minimizing its total exposure to a no-fault claim. Should such a procedure be required every time there is litigation, it places the no-fault insurer in a position to minimize its exposure by settling a claim for a fractional amount. Once this total fractional amount is determined for the entire claim, each and every claimant who is entitled to be paid benefits on the claim is forced to appear in court and fight for his or her own individual share of the compromised settlement amount. Instead of receiving a reasonable charge for services rendered to the injured person, each claimant will only receive a fractional amount of that charge. Furthermore, placing insurers in a superior bargaining position such as this only encourages an insurer to litigate its claims—which would clearly frustrate the No-Fault Act's goal of providing prompt economic reparations for accident victims without the need for litigation.

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child from two marriages, and there is no dispute as to the total amount of the survivors loss benefits owed, but there is a doubt as to how much of that amount should be allocated between the two minor children.

The *Covenant* regime has resulted in confusion, and has dramatically increased the end-of-case motion practice. This increases the cost of litigation to the parties and has flooded our courts. The elaborate procedure that has resulted from the *Covenant* regime is neither required nor authorized under the no-fault law, and must therefore be disavowed.

V. The issue of whether medical providers should lose their statutory right to pursue independent claims for payment of services, and the related issue of how such claims should be processed by the court system, are issues that should be left to the Legislature for determination—as they are fundamentally related to the overall implementation and enforcement of the no-fault system.

As was thoroughly discussed above, and as has been consistently recognized by Michigan appellate courts for decades, a medical provider's direct right of action is a statutory right that is clearly and unambiguously established by the Legislature's chosen language in MCL 500.3112 of the auto no-fault act. Because this legal right is the product of legislative enactment, this Court must remain *"faithful to the actual statutory text and thus the intent of the lawgiver." Progressive Michigan Ins Co v Smith,* 490 Mich 977; 806 NW2d 494 (2011) (Young, C.J. concurring). Accordingly, this court cannot use this case as a vehicle to divest medical providers of this right. That right can only be taken away by Legislative amendment to the language of § 3112. Accordingly, unless or until that occurs, this Court must give full recognition to this right, and continue to enforce it as the rule of law.

Similarly, this case is not the proper mechanism to resolve the procedural logistics of how a provider action should be processed within the no-fault system. Resolving this

issue is also fundamentally legislative, as it deals with the basic administrative operation of the statutory no-fault system. To the extent that provider claims require establishing new "*rules of procedure,*" those rules should not be decided or crafted by this court within the context of this case. Rather, appropriate rules should only be adopted by this Court pursuant to the Court's constitutional authority to promulgate court rules, and only after ample opportunity for input by the bench, bar, and the public at large.

CONCLUSION AND REQUEST FOR RELIEF

WHEREFORE, for the foregoing reasons, CPAN respectfully requests that this Court issue an Opinion and Order clarifying:

(1) That a healthcare provider has a legal right to assert a claim directly against a no-fault insurer for that is both independent and derivative;

(2) That a healthcare provider constitutes "*some other person*" within the meaning of the second sentence of MCL 500.3112; and

(3) That a § 3112 hearing should only be used in those limited situations where there is no dispute as to the amount owed by the insurer, but there is doubt as to whom benefits should be paid. It should not be used as a mechanism for an insurer to adjudicate whether an insurer owes benefits, or as a mechanism to discount the claims of providers who are not a party to that litigation.

Respectfully submitted,

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Dated: October 6, 2016

DIFS Department of Insurance and Financial Services

Bulletin No. 92-03

Disputes between no-fault automobile insurers and health care providers

Issued and entered October 23, 1992 by David J. Dykhouse, Commissioner of Insurance

Section 3107(1)(a) of the Insurance Code of 1956, MCLA 500.3107(1)(a); MSA 24:3107(1)(a), establishes the responsibilities of no-fault auto insurers with respect to economic losses other than wage loss under personal protection insurance benefits:

> Sec. 3107.(1) Except as provided in subsection (2), personal protection insurance benefits are payable for the following:
>
> (a) Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation. Allowable expenses within personal protection insurance coverage shall not include charges for a hospital room in excess of a reasonable and customary charge for semiprivate accommodations except if the injured person requires special or intensive care, or for funeral and burial expenses in the amount set forth in the policy which shall not be less than $1750.00 or more than $5,000.00.

The Insurance Bureau has received reports that no-fault insurers have questioned the reasonableness of some of the charges billed by health care providers for services rendered to their insureds and claimants following a motor vehicle accident. In some instances where the insurer and the provider have been engaged in such a dispute, the health care provider has billed the patient for the disputed amount and has vigorously pursued collection from the insureds or claimant directly.

The purpose of this bulletin is to remind no-fault insurers that they are required to provide insureds and claimants with complete protection from economic loss for benefits provided under personal protection insurance. Auto insurers must act at all times to assure that the insured or claimant is not exposed to harassment, dunning, disparagement of credit, or lawsuit as a result of a dispute between the health care provider and the insurer.

When such a dispute arises, an insurer will meet its statutory obligations by adhering to the following procedures. First, the insurance company must assume its statutory responsibility for complete protection of the insured. To do so, the insurer should notify the provider that the insurer is responsible for paying any reasonable charges, not the insured or claimant. Second, the insurer must also assure the policyholder or claimant of its responsibility. Insureds and claimants should be given directions on how to handle any bills or collection notices they receive. Third, the insurer should notify collection agencies and credit reporting agencies to disregard medical providers' claims against the insured for services covered under personal injury protection benefits. And finally, health care providers should be warned that the insurer will defend the insured or claimant against any attempt to collect, and may also consider any other appropriate action to prevent its policyholder from being pursued for collection.

A dispute between a medical provider and the insurer as to the reasonableness of the charge for services does not void the insurer's obligation to its insureds and claimants to pay the amount ultimately determined to be reasonable. The insurer also has an obligation to protect its insureds and claimants from any consequences of such a dispute.